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Issue Date: 03 November 2005

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In the Matter of:

JOHN P. LOONEY
Claimant

v. **Case No.: 2002-BLA-00122**
SHADY LANE COAL CORPORATON,
Employer, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

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DECISION AND ORDER ON REMAND GRANTING BENEFITS

The above-captioned matter is on remand from the Benefits Review Board. In its November 26, 2004 decision, the Benefits Review Board (hereafter "Board") vacated the undersigned's Decision and Order Granting Modification and Benefits of September 12, 2003. For the reasons set forth below, I uphold my prior award of benefits.

This proceeding arises from the second claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by Claimant John Looney ("Claimant") on May 29, 1997. The instant claim is a modification request of the second claim filed on January 17, 2001 by Claimant to the District Director. The putative responsible operator is Shady Lane Coal Corporation ("Employer").

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980. 20 C.F.R. §718.2. [1] In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[2] The

[1] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[2] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

Department of Labor amended the regulations on December 15, 2003, solely for the purposes of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law hereafter are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

Claimant filed the first claim for benefits on July 19, 1991, and the District Director denied the award of benefits on November 25, 1991. (DX 139-1 to DX 137-17) [3].

On November 22, 1996, Claimant filed the second application for benefits, which is currently before me. (DX 1). The second claim was originally granted on May 29, 1997 by the District Director (DX 22) but was denied by Administrative Law Judge Edward J. Murty, Jr. on July 29, 1998, because he determined, based upon a hearing on the record, that the Claimant was not totally disabled and did not have complicated pneumoconiosis. (DX 37). In the Decision and Order Denying Benefits, Judge Murty also found that the Claimant had 15 years three months and 23 days of coal mine employment, that he had one dependent (his wife Pamela Joy),[4] and that Shady Lane Coal Company was properly designated as the responsible operator. (DX 37). On August 27, 1998 Claimant filed a Motion for Reconsideration (DX 38), and Associate Chief Judge Thomas M. Burke issued an Order denying reconsideration on October 27, 1998 based upon the determination that the issues raised were more appropriately raised on appeal. (DX 39). Both decisions were affirmed by the Benefits Review Board on December 14, 1999. (DX 49).

Claimant filed a modification request regarding the second application on February 23, 2000 and later withdrew the request.[5] (DX 50) Thereafter, Claimant refiled the same modification request on March 30, 2000. (DX 58). The district director denied the modification request on October 3, 2000, because the additional evidence failed to establish total disability and thus the evidence did not establish a change in conditions or a mistake in determination of fact, so as to establish a basis for modification under 20 C.F.R §725.310. (DX 86).

Thereafter, Claimant filed another modification request with the District Director on January 17, 2001, submitting new evidence. (DX 89). On August 7, 2001, the District Director reviewed all of the medical evidence and denied the claim again based upon the failure to prove total disability or complicated pneumoconiosis. (DX 134). Claimant requested a hearing and the case was transmitted to the Office of Administrative Law Judges on November 9, 2001. (DX 135, 140, 141).

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[3] References to the Director's Exhibits 1 through 141 appear as "DX 1" through "DX 141", and Employer's Exhibit 1 admitted into evidence at the May 23, 2002 hearing, appear as "EX 1," respectively. References to the hearing transcript appear as "Tr." followed by the page number.

[4] At the hearing before me, Claimant's wife's name was mistranscribed as "Thelma"; her correct name is "Pamela Joy." (Tr. 13; compare DX 1, 9).

[5] Claimant's attorney sent a letter to the District Director stating that he intended to file a new claim and not a modification, and the District Director informed him that one year must elapse after the last denial before the application would be considered a new claim and not a modification. (DX 51, 52)

A hearing was held before the undersigned administrative law judge on May 23, 2002. I issued a Decision and Order Granting Modification and Benefits on September 12, 2003. In the prior Decision, I found that Claimant established complicated pneumoconiosis, which evoked the irrebuttable presumption that he is totally disabled due to pneumoconiosis. Employer appealed the Decision to the Board on October 14, 2003.

In a Decision and Order of November 26, 2004, the Benefits Review Board vacated my prior Decision, with one judge dissenting. The Board stated, in relevant part:

> The administrative law judge's determination that claimant established invocation of the irrebuttable presumption pursuant to Section 718.304(c) based on the opinion of Dr. Forehand, who relied on x-ray and CT scan evidence thus, conflicts with her findings that the x-ray and CT scan evidence was inconclusive under Section 718.304(a) and (c), respectively. The administrative law judge failed to resolve this conflict inherent in her finding at Section 718.304 and we thus vacate this determination.

Looney v. Shady Lane Coal Corp., BRB No. 04-0119 BLA (Nov. 26, 2004) (unpub.) The Board remanded the case for proceedings consistent with their holding. *Id.* at 8.

On remand, the case was docketed on April 6, 2005 and a notice of assignment was issued on April 21, 2005, permitting the parties to submit briefs. Respondent filed a Brief on Remand (which had originally been filed with a motion for leave to file in January 2005) on May 2, 2005. Claimant submitted a Brief in Support of Award of Benefits on June 7, 2005 along with a request to accept the brief as timely. Claimant's request is granted and both briefs submitted are accepted as timely. **SO ORDERED.**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

The following matters are at issue (DX 140, Tr. 6-8):

1. Timeliness of the claim;[6]

2. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled;

[6] Employer admitted during the hearing that its timeliness argument was contrary to current case law. (Tr. 8). Departmental regulations allow the filing of multiple claims, provided that the criteria in sections 725.309 and 725.310 have been satisfied. Employer has offered nothing further on this point apart from its unsupported argument that "these proceedings are not in the interest of justice." Employer's Brief at page 6, note 1. Thus, I find, as I did previously, that the presumption of timeliness in §725.308(c) has not been rebutted.

5. Whether Claimant's disability is due to pneumoconiosis;

6. Whether the evidence establishes a material change in conditions under § 725.309(d) (1999) (refiled claims);

7. Whether the evidence establishes a change in conditions and/or a mistake in determination under § 725.310 (1999) (modification); and

8. Length of coal mine employment.[7]

(DX 140; Tr. 6-8.) There were also a number of issues listed for appellate purposes. *Id.* At the hearing, Employer's counsel indicated that while the Employer could not enter into a stipulation on the responsible operator issue, it did not dispute Claimant's employment by Shady Lane from December 8, 1981 to December 21, 1990, as reflected by its bookkeeper's statement. (Tr. 7, 19-20; DX 6). It also agreed to one dependent (Claimant's wife) contingent upon his consistent testimony, and Employer withdrew the issue at the end of the hearing. (Tr. 6, 13. 19).

Medical Evidence[8]

The newly submitted medical evidence (dated after December 14, 1999) consists of the following[9]:

(1) An examination report by Dr. Emory Robinette, on June 28, 2000, together with the x-ray findings, pulmonary function testing, arterial blood gases, and electrocardiogram (all testing dated 5/19/00) for that exam (DX 94)[10];

(2) An examination report by Dr. Hippensteel on August 21, 2000, together with the x-ray reading, pulmonary function testing, arterial blood gases, and electrocardiogram for that exam. (DX 88);

(3) An examination report by Dr. Rasmussen, on December 19, 2000, together with the x-ray reading (by Dr. Patel), pulmonary function testing, arterial blood gases, and electrocardiogram for that exam (DX 94);

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[7] As noted below, Judge Murty found 15 years, three months and 23 days of coal mine employment, which is the law of the case. However, Claimant's testimony established 23 years ending in 1991. (Tr. 10).

[8] The final decision regarding the second application was issued on December 14, 1999 by the Board, and thus all evidence submitted after that date is considered new evidence and will be considered in determining "change of condition." *Shertzer v. McNally Pittsburg Manufacturing Co.,* BRB No. 97-1121 BLA (June 26, 1998) (unpub.)

[9] Claimant submitted May 19, 2000 pulmonary function test (DX 83) that were not in accordance with the with the standards as described in 20 CFR 718 and thus will not be considered. Also, the chest PA report dated 5/19/00 by Dr. Coburn was not consistent with the ILO format and will not be considered.

[10] The second application was filed on November 22, 1996 before the evidentiary limitations were implemented. Therefore, it is unnecessary to designate the medical evidence for evidentiary limitation purposes. §725.309 (2001) (amended regulations became effective January 19, 2001).

(4) An examination report by Dr. Castle, on May 23, 2001, together with the x-ray reading, pulmonary function testing, arterial blood gases, and electrocardiogram (all testing dated 3/19/01) for that exam (DX 129);

(5) An examination report by Dr. Forehand, on January 27, 2000, with a CT scan (DX 61);

(6) Readings of May 19, 2000, August 21, 2000, October 19, 2000, and December 19, 2000 x-rays by Dr. Wheeler (DX 85, 98, 133);

(7) Readings of May 19, 2000, August 21, 2000, October 19, 2000, and December 19, 2000 x-rays by Dr. Scott (DX 85, 98, 133);

(8) A CT Scan dated January 27, 2000 by Dr. Darlak (DX 61);

(9) A CT Scan dated January 27, 2000 by Dr. Forehand (DX 61);

(10) A reread of CT scan dated January 27, 2000 by Dr. Wheeler on July 6, 2000 (DX 80);

(11) A reread of CT scan dated January 27, 2000 by Dr. Scott on July 7, 2000 (DX 80);

(12) A medical record from Johnston Memorial Hospital dated May 19, 2000 (DX 87);

(13) A reread of a CT Scan dated January 27, 2000 by Dr. Scott on January 30, 2001 (DX 98);

(14) Readings of May 19, 2000, October 19, 2000, and December 19, 2000 x-rays by Dr. Sargent (DX 111, 112, 113);

(15) A reading of August 21, 2000 x-ray by Dr. Hippensteel (DX 88);

(16) A reading of October 19, 2000 x-ray by Dr. Deponte (DX 89);

(17) A reading of December 19, 2000 x-ray by Dr. Patel (DX 94);

(18) A reading of March 19, 2001 x-ray by Dr. Barrett (DX 132);

(19) Readings of August 27, 1991, January 6, 1997, January 27, 2000, and August 21, 2000 x-rays by Dr. Navani (DX 125, 126, 127).

Discussion

The Black Lung Benefits Act provides benefits to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis. 20 C.F.R. §718.1(a). In addition to establishing the existence of pneumoconiosis, a claimant must prove that (1) the pneumoconiosis

arose out of coal mine employment; (2) he or she is totally disabled, as defined in section 718.204; and (3) the total disability is due to pneumoconiosis. §§718.202 to 718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

The instant claim encompasses both a duplicate or refiled claim and multiple requests for modification. Specifically, the proceedings before me arise out of modification requests filed by Claimant at the District Director level relating to the denial of the instant, duplicate black lung claim. The instant case thus involves two threshold issues – whether there has been a change in conditions or mistake in determination of fact so as to give rise to modification under §725.310 (1999), and whether there has been a material change in conditions so as to provide grounds for reopening a duplicate claim under §725.309 (1999).

Modification. The standards for granting a request for modification of a previous denial of benefits, as the Claimant seeks here, are set forth in the regulations at §725.310(a) (1999), which states, in pertinent part:

> Upon . . . the request of any party on grounds of a change in conditions or because of a mistake in a determination of fact, the deputy commissioner [district director] may, . . . at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

In determining whether a "change in condition" is established, the fact-finder must conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against claimant. *Kingery v. Hunt Branch Coal Co.***,** 19 B.L.R. 1-6 (1994).

An administrative law judge may also grant modification premised upon a mistake in determination of fact based upon an allegation that the ultimate fact was mistakenly decided; "[t]here is no need for a smoking-gun factual error, changed conditions, or startling new evidence." *Jessee v. Director, OWCP*, 5 F.3d 723, 725 (4th Cir. 1993). The *Jessee* court continued by explaining that, in looking for a mistake in fact: "No new evidence is required. A claims examiner may 'correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted.'" ***Id.*** at 724 (quoting *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971) (per curiam) (decided under Longshore and Harbor Workers' Compensation Act)). If a basis for modification is found, the claim must be considered on the merits, based upon all the evidence of record. *See Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156, 1-158 (1990), *modified on recon.*, 16 B.L.R. 1-71, 73 (1992).

Material Change in Conditions. The instant case is also a duplicate claim. Such a claim should be denied based upon the prior denial (here, Claimant's failure to establish that he was totally disabled by pneumoconiosis) unless the claimant can establish a material change in conditions. *See* §725.309(d) (1999). Accordingly, the general rule is to require that the administrative law judge make a threshold determination as to whether the evidence submitted since the final denial is sufficient to establish a material change in conditions pursuant to §725.309 (1999). If it is, the merits of the claim should be considered. If it is not, the claim must be denied.

This case arises under the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit, as the Claimant's usual and last coal mine employment took place in Virginia. *See* §725.482. The standard for finding a "material change in conditions" is governed by the Fourth Circuit's holding in *Lisa Lee Mines v. Director, OWCP,* 86 F.3d 1358 (4th Cir. 1996) (*en banc*). In *Lisa Lee Mines*, the Court adopted the Director's one-element standard, "which requires the claimant to prove, under all of the probative medical evidence of his condition after the prior denial, at least one of the elements previously adjudicated against him." *Id.*

The Benefits Review Board remanded the case in order for the undersigned to conduct a full and comparative weighing of all relevant evidence and determine whether the evidence is sufficient to invoke the irrebuttable presumption [of total disability due to complicated pneumoconiosis] at Section 718.304. *Looney***,** BRB No. 04-0119 BLA (Nov. 26, 2004) (unpub.), at 6. If complicated pneumoconiosis is established, a material change is conditions and a basis for modification will also be established. Therefore, I will begin by determining whether Claimant has established complicated pneumoconiosis.

Complicated Pneumoconiosis

If Claimant can establish complicated pneumoconiosis (also known as "massive pulmonary fibrosis"), under the criteria set forth in 30 U.S.C. § 921(c)(3) and §718.304, he is entitled to an irrebutable presumption of total disability due to pneumoconiosis. *See generally Usery v. Turner Elkhorn Mining Co.***,** 428 U.S. 1 (1976) (upholding constitutionality of presumption). Pursuant to §718.304, a claimant may be entitled to the irrebuttable presumption of total disability due to pneumoconiosis, under paragraph (a), based upon a chest x-ray finding of one or more large opacities (*i.e.,* greater than 1 centimeter in diameter) which would be classified as Category A, B, or C under the applicable classification requirements (such as ILO and UICC); under paragraph (b), based upon a biopsy yielding "massive lesions in the lung"; or, under paragraph (c), based upon a condition which "when diagnosed by means other than those specified in paragraphs (a) and (b) . . . could reasonably be expected to yield the results described in paragraph (a) or (b) . . . had diagnosis been made as therein described: *provided, however,* that any diagnosis made under this paragraph shall accord with acceptable medical procedures." §718.304.

These clauses are intended to describe a single, objective condition, and subsection (a) provides an objective standard against which the other subsections can be measured. *See Eastern Associated Coal Corporation v. Director, OWCP [Scarbro]***,** 220 F.3d 250, 255-57 (4th Cir. 2000). The statutory definition of complicated pneumoconiosis need not be congruent with

a medical or pathological diagnosis. *Id.* at 257. *See also Double B Mining, Inc. v. Blankenship,* 177 F.3d 240 (4th Cir. 1999) (declining to adopt blanket 2 centimeter rule for pathology findings and instead requiring an equivalency determination to be made); *Handy v. Director, OWCP,* 16 B.L.R. 1-73 (1990) (finding that an x-ray report indicating the absence of small or large opacities consistent with pneumoconiosis, but noting the presence of a 1.0 centimeter lesion in the right lung, was legally insufficient to establish the existence of complicated pneumoconiosis because section 718.304(a) requires a finding of one or more large opacities greater than one centimeter in diameter.) An equivalency determination must be made regardless of whether there is x-ray or pathological evidence of record. *Braenovich v. Cannelton Industries, Inc.*, 22 B.L.R. 1-237 (2003). In *Braenovich*, the Board upheld the administrative law judge's finding of complicated pneumoconiosis based upon his equivalency determination that a 1.5 centimeter lesion on autopsy would produce an opacity of equivalent size on x-ray even though he found both the x-ray evidence and the autopsy evidence to be insufficient to establish complicated pneumoconiosis, because "'[e]vidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict.'"[11] *Id., citing Scarbro.*

While the section does not specifically require that a diagnosis of pneumoconiosis be associated with the lesions found, that requirement has been read into the regulation by the Benefits Review Board. In *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*), the Board stated that, because section 718.304 offered no opportunity for rebuttal, failure by an administrative law judge to consider all relevant evidence at the invocation stage could constitute a violation of an opposing party's due process rights. The Board held that:

> . . . the administrative law judge shall first determine whether the evidence in each category tends to establish the existence of complicated pneumoconiosis, and then must weigh together the evidence at subsections (a), (b) and (c) before determining whether invocation of the irrebuttable presumption pursuant to Section 718.304 has been established.

The Board noted that CT scans fit under subsection (c). *Id.* In *Braenovich, supra,* the Board indicated that under the Fourth Circuit's mandate in *Blankenship, supra***,** "the administrative law judge is bound to perform equivalency determinations to make certain that, regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption."

It is in the context of this precedent, as well as the Board's remand decision, that I will consider the evidence of record under section 718.304.

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[11] The majority of the Board in *Braenovich* determined that the administrative law judge's determination properly fit under subsection (c) of section 718.304 but the dissent maintained that it should have been considered autopsy or biopsy evidence under subsection (b). Thus, neither the majority nor the dissent applied the *Melnick* requirement of weighing the evidence under all three paragraphs together. The conflict arose in view of the assertion by some of the experts that there is a two-centimeter requirement for a pathological diagnosis of pneumoconiosis whereas there was also evidence that lesions on biopsy would result in approximately equivalent opacities on x-ray.

Subsection (a): X-rays. Since the time that the previous denial became final, the following x-ray readings were submitted:

Exhibit No.	Date of X-ray/ Reading	Physician/ Qualifications	Interpretations
DX 125	**August 27, 1991**/ May 19, 2001	Shiv Navani BCR & B-Reader	q/q; all zones; 1/2; quality 2
DX 126	**January 6, 1997**/ May 19, 2001	Shiv Navani BCR & B-Reader	q/r; all zones; 2/1; large A opacities; quality 2
DX 127	**January 27, 2000**/ May 19, 2001	Shiv Navani BCR & B-Reader	q/r; all zones; 2/1; large A opacities; quality 1 (pulmonary parenchymal changes are consistent with CWP)
DX 85	**May 19, 2000**[12]/ August 14, 2000	Paul S. Wheeler, BCR & B-Reader	q/q; upper four zones; 1/0; quality 1 (infiltrates compatible with granulomatous disease possibly mixed with CWP, compatible with conglomerate tuberculosis ("TB")).
DX 85	May 19, 2000/ August 15, 2000	William W. Scott, Jr. BCR & B-Reader	q/q; upper four zones; 1/1; quality 1 (peripheral infiltrate compatible with TB, probable silicotuberculosis)
DX 94	May 19, 2000	Emory Robinette B-Reader	q/q; all zones; 3/2; large opacities C; quality 1 (right hilar mass, 2.5 cm)

[12] There is one additional x-ray interpretation of the May 19, 2000 by Dr. Earnest Coburn (DX 94), but it will not be considered inasmuch as it is not in compliance with the ILO classification standards. *See* §718.102(c) (2001).

DX 111	May 19, 2000/ March 6, 2001	E. N. Sargent BCR & B-Reader	q/q; all zones; 2/3; large A opacities; quality 1 (rule out granulomatous disease in upper lobes)
DX 88	**August 21, 2000**	Kirk E. Hippensteel B-Reader	q/r; upper four zones; 2/2; quality 1 (partially calcified apical infiltrates, calcification in bilateral hilar lymph nodes)
DX 98	August 21, 2000/ January 26, 2001	William W. Scott, Jr. B-Reader & BCR	q/t; upper four zones;1/2; quality 1 (background of rounded and irregular small opacities which could be silicosis or TB).
DX 98	August 21, 2000/ January 26, 2001	Paul S. Wheeler, BCR & B-Reader	q/q; upper four zones; 1/0; quality 1 (minimal small nodular infiltrate in mid and upper lungs compatible with granulomatous disease, most likely TB but some nodules could be silicosis or CWP)
DX 106	August 21, 2000/ February 18, 2001	Shiv Navani, BCR & B-Reader	q/q; all zones; 2/1; large opacities A; quality 3.
EX 1	August 21, 2000/ January 15, 2002	Thomas M. Hayes, BCR & B-Reader	q/q; all zones; 1/1; quality 1.
DX 89	**October 19, 2000**/ October 26, 2000	Kathleen A. Deponte, BCR & B-Reader	q/q; all zones; 3/2; large opacities B; quality 1

DX 133	October 19, 2000/ April 21, 2001	Paul S. Wheeler BCR & B-Reader	q/q; upper four zones; 1/1; quality 2 (small nodular infiltrate in mid and upper lungs compatible with granulomatous disease most likely TB, some could be silicosis or CWP)
DX 112	October 19, 2000/ March 6, 2001	E. N. Sargent BCR & B-Reader	q/q; all zones; 2/3; large B opacities; quality 1 (rule out associated granulatamous disease in upper lobes)
DX 133	October 19, 2000/ April 20, 2001	William Scott, Jr. BCR & B-Reader	q/q; all zones; 2/2; quality 2 (peripheral upper zone infiltrates probably due to TB; hyperinflation lungs compatible with emphysema; hilar elevation due to upper lung fibrosis)
DX 113	**Dec. 19, 2000**/ March 6, 2001[13]	E. N. Sargent BCR & B-Reader	q/q; all zones; 2/3; large A opacities; quality 2
DX 94	Dec. 19, 2000	Manu Patel B-Reader & BCR	q/q; all zones; 3/2; large opacities B; quality 1
DX 133	Dec.19, 2000/ April 21, 2001	Paul S. Wheeler BCR & B-Reader	q/q; upper four zones; 1/0; quality 2 (nodular infiltrate compatible with TB, silicosis or CWP; TB can cause all lung findings; CWP typically gives small round nodules in central portion)

[13] Director's Exhibit No. 114 and 115 is a reading of the same x-ray dated 12/19/00. The only distinction noted is the film quality. DX 114 has the film quality marked "3" overexposed, and DX 115 has a film quality of "1".

DX 133	Dec. 19, 2000/ April 20, 2001	William Scott, Jr. BCR & B-Reader	q/q; all zones; 2/2; quality 1 (peripheral infiltrates due to TB; hyperinflation in lungs compatible with emphysema; hilar elevation due to upper lung fibrosis)
DX 132	**March 19, 2001**/ June 13, 2001	Peter T. Barrett BCR & B-Reader	q/q; 2/3; large A opacities; quality 1[14]
DX 129	March 19, 2001/ May 16, 2001	James R. Castle B-Reader	q/r; all zones; 2/2; quality 1 (partially calcified apical lesions and lymph notes consistent with granulomatous changes, right hilar fullness needs comparison with old films).

In determining the existence of pneumoconiosis based on chest x-ray evidence, "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." 20 C.F.R. §718.202(a)(1). The Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified Radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

January 27, 2000 x-ray: There was one interpretation of the January 27, 2000 x-ray, by dually qualified B-Reader and Board-certified radiologist Dr. Shiv Navani, in which he found large "A" opacities. Therefore, this x-ray supports a finding of complicated pneumoconiosis.[15]

May 19, 2000 x-ray: There are four interpretations of this x-ray film with two physicians finding complicated pneumoconiosis while the remaining two physicians found to the contrary. Dr. Wheeler found infiltrates possibly compatible with CWP associated with granulomatous disease (such as tuberculosis) and Dr. Scott found scarring suggestive of silicotuberculosis. However, I must note that Drs. Wheeler and Scott found one or more opacities meeting the

[14] Dr. Barrett failed to complete the "zones" section of the x-ray form to indicate which zones the opacities were present.

[15] In my previous decision, I apparently missed this x-ray reading.

regulatory definition but did not find the opacities to be CWP, while Dr. Robinette found large "C" opacities and Dr. Sargent found large "A" opacities to support a finding of complicated pneumoconiosis. Drs. Wheeler, Scott, and Sargent, each of whom is a board certified radiologist and a certified B-Reader, hold the highest qualifications, while Dr. Robinette is only a certified B-Reader. Among the most qualified readers, there are conflicting opinions with one (Dr. Sargent) finding complicated pneumoconiosis and two (Drs. Wheeler and Scott) finding to the contrary. Although there are two negative interpretations compared to one positive reading among qualified physicians, I will not defer to numerical superiority in this case because all readers are equally qualified. The Board has held that an administrative law judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolvervine Mining Co.,* 14 B.L.R. 1-70 (1990). Therefore, the evidence is in equipoise neither supporting nor undermining a finding of complicated pneumoconiosis.

August 21, 2000 x-ray: Similarly, there are differing opinions regarding the August 21, 2000 x-ray among equally qualified physicians. Dr. Hippensteel, who did not find complicated pneumoconiosis, only holds B-Reader qualifications while the other physicians are both board certified radiologists and B-Readers. Among the equally qualified physicians, only one (Dr. Navani) cited a large "A" opacity in the x-ray constituting complicated pneumoconiosis, while the remaining three physicians (Drs. Scott, Wheeler, and Hayes) found no large opacities in the x-ray readings. However, Drs. Wheeler and Scott again found one or more opacities meeting the regulatory definition. As stated above, I will not defer to numerical superiority in weighing evidence submitted by equally qualified physicians, and thus I find that the x-ray evidence relating to the August 21, 2000 film is also in equipoise.

October 19, 2000 x-ray: Four physicians, who are all board certified radiologists and certified B-Readers, submitted interpretations concerning the October 19, 2000 x-ray, with the readings equally split regarding complicated pneumoconiosis. Drs. Deponte and Sargent both found large "B" opacities warranting a finding of complicated pneumoconiosis, while Drs. Wheeler and Scott only cited small opacities. Again, the evidence regarding this x-ray is also equal and inconclusive in establishing complicated pneumoconiosis.

December 19, 2000 x-ray: Similarly, the December 19, 2000 film was interpreted by four equally qualified (BCR & B-Reader) physicians with two physicians finding complicated pneumoconiosis and two physicians finding to the contrary. Based upon the disagreement among the equally qualified readers, this x-ray also fails to support or negate a finding of complicated pneumoconiosis.

March 19, 2001 x-ray: This x-ray was read by two physicians. Dr. Barrett, who is both a board certified radiologist and B-Reader, found large "A" opacities satisfying the requirement for complicated pneumoconiosis; however, Dr. Castle disagreed in only small "q/r" opacities. Dr. Barrett's reading is given greater weight based upon his higher radiological credentials as both a board certified radiologist and B-Reader, and thus the March 19, 2001 x-ray supports a finding of complicated pneumoconiosis.

Additionally, Dr. Navani submitted two x-ray re-readings relating to x-rays predating the Board decision. The August 27, 1991 x-ray interpretation cited 1/2 CWP through "q/q"

opacities, while the January 6, 1997 found large "A" opacities. However, Dr. Navani checked the box for TB on the January 1997 x-ray form, suggesting an etiology in addition to complicated pneumoconiosis. However, as noted above, the January 27, 2000 reading by Dr. Navani supports a finding of complicated pneumoconiosis, and a comparison of the August 27, 1991 x-ray readings with later x-ray readings (which showed large opacities) suggests a worsening of Claimant's condition and is compatible with the progressive nature of pneumoconiosis. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989) (en banc).

After re-evaluating the newly submitted x-ray evidence, as the Board directed, in the context of the previous record, I find that the evidence is not in equipoise but that the Claimant has proven complicated pneumoconiosis through x-ray evidence under §718.304(a). Although the majority the new x-rays (dated May 19, 2000, August 21, 2000, October 19, 2000, and December 19, 2000) were equivocal on the issue of complicated pneumoconiosis, with conflicting interpretations among equally qualified physicians, and therefore may be deemed in equipoise, the March 19, 2001 and January 27, 2000 x-rays support a finding of complicated pneumoconiosis, sufficiently weighing the evidence in favor of the Claimant. Moreover, a comparison of the August 27, 1991 x-ray with later x-rays shows the progressiveness of the Claimant's condition, thereby supporting a finding of pneumoconiosis progressing to complicated pneumoconiosis. For such reason, I find that Claimant has established complicated pneumoconiosis by a preponderance of the x-ray evidence.

Subsection (b): Pathological evidence. There is no biopsy of record, and thus subsection (b) can not be satisfied.

Subsection (c): Other Evidence. The other newly submitted evidence on the issue of complicated pneumoconiosis consists of CT scan reports and medical opinion evidence.

CT Scans. The following CT scan interpretations were submitted:

Dr. Darlak (1/27/00 CT): Dr. Darlak found contractive scarring with confluent nodules in the apices bilaterally and diffuse micronodularity present as well. The report noted a diffuse nodular pattern throughout both lung fields with nodules "2 or 3 mm in diameter" and larger together with subpleural blebs and cysts and some larger nodules in the pulmonary parenchyma with no apparent parenchymal or mediastinal calcification and no evidence of cavitation, infiltrate, or active disease. The impression stated that the findings were consistent with pneumoconiosis such as silicosis. (DX 60).

The same report was resubmitted and signed by Dr. Darlak, and the impression was amended to state that findings are "consistent with pneumoconiosis such as silicosis or **silico-tuberculosis**" and suggested possible malignancy (DX 70).

Dr. Forehand (1/27/00 CT): Dr. Forehand noted bilateral, noncavitating upper lobe masses with blebs and cysts and underlying diffuse nodules. He noted that this appearance was unique to complicated coal workers' pneumoconiosis (CWP). The report also noted that tuberculosis or

fungal lung disease would be cavitary, and that a malignancy would not appear as mirror image bilateral lung masses. He also addressed other matters. (DX 61).[16].

Dr. Wheeler (reread of 1/27/00 CT dated 7/6/00): Dr. Wheeler noted a few small masses compatible with conglomerate TB or Fibrosis in apices; and upper lungs including periphery with few tiny pleural scars compatible with granulomatous disease. He opined that TB was more likely than histoplasmosis because TB is more likely to involve upper lungs selectively and self cure. (DX 80).

Dr. Scott (reread of 1/27/00 CT dated 7/7/00): Dr. Scott found peripheral infiltrates and/or fibrosis in the upper lungs. These changes probably were due to healed TB although activity cannot be excluded. There are also a few more widely-distributed small rounded opacities in the mid and upper lungs which could be due to silicosis/CWP. (DX 80).

Dr. Scott (reread of 1/27/00 CT dated on 1/30/01): With respect to the same CT scan, Dr. Scott noted focal scarring in the periphery of both apicies with pleural extension and calcified granulomata. He also noted scattered nodules, about 1 cm in diameter, in the periphery of the lung down to the level of the carina and a background of small rounded opacities in the mid and upper lungs of moderate profusion which could be due to TB or silicosis/CWP. (DX 98).

Dr. Navani (re-read of 1/27/00 CT dated 5/19/01): Dr. Navani found small opacities "q/r" in all six zones with 2/2 profusion and large "A" opacities noted with a film quality of "1". He also noted pulmonary parenchymal changes consistent with CWP.

There are conflicting opinions regarding the January 27, 2000 CT Scan. Drs. Forehand and Navani's findings of complicated pneumoconiosis were contrary to those of Drs. Wheeler and Scott, who essentially found small opacities consistent with tuberculosis or silicosis. Although in one report Dr. Scott noted scattered nodules of "about 1 cm." in diameter, such a finding is insufficient to establish complicated pneumoconiosis. Dr. Darlak's report was inconclusive on the issue of complicated pneumoconiosis, because he indicates that that nodules "2 or 3 mm in diameter and larger" were found but failed to address the issue of complicated pneumoconiosis. Moreover, the re-submitted report raises concerns about his findings, because he altered his opinion by adding "silico-tuberculosis" to the report. Based upon his failure to address complicated pneumoconiosis and inconsistencies between the two reports, Dr. Darlak's report is given less weight. The remaining reports are distinguishable based upon the physician's credentials. Dr. Forehand is a certified B-Reader while Drs. Wheeler, Scott and Navani hold higher radiological qualifications as both B-Readers and board certified radiologists. Among the equally qualified physicians, there are conflicting opinions. Based upon these conflicting opinions, the evidence is in equipoise, and thus Claimant has failed to satisfy the preponderance of the evidence standard based upon the CT scan evidence.

Medical opinion evidence. However, the preponderance of the medical opinion evidence establishes complicated pneumoconiosis. The following physicians submitted medical opinions on the issue of complicated pneumoconiosis:

[16] Dr. Forehand's report (DX 61) qualifies as both a CT scan report and a medical opinion, and thus it will be considered under both sections.

- Dr. J. Forehand, submitted a January 27, 2000 medical report as treating physician. (DX 61).
- Dr. Emory Robinette, submitted a June 28, 2000 medical report. (DX 94)
- Dr. Kirk Hippensteel, submitted a August 21, 2000 medical report. (DX 88).
- Dr. D.L. Rasmussen, submitted a December 19, 2000 medical report. (DX 94).
- Dr. James Castle, submitted a May 23, 2001 medical report. (DX 129).

(1) J. Forehand, M.D., (B-Reader and treating physician) discussed the findings from the CT scan on January 27, 2000 and prepared a medical report. He stated that the examination was to follow upon on the progressive radiographic changes of the Claimant's lungs.

The report stated that the spirogram showed an obstructive ventilatory pattern, and the CAT Scan of the chest revealed bilateral, noncavitating upper lobes masses that are unique to complicated CWP. He was able to rule out TB and fungal lung disease, and he noted that Claimant twice tested negative for TB. Also, he stated that TB and fungal lung disease may be bilateral but at this stage would be cavitary. He also stated that if a malignancy were involved, it would not show up as bilateral mirror images and, at this stage, it would be metastatic, leading to emaciation and death.

He further stated that Claimant has a totally and permanently disabling chronic lung disease manifesting as complicated CWP. He stated twenty-five (25) years of underground coal mining work was the cause of his complicated pneumoconiosis and his smoking history of at least 12 years had not contributed to the disease. He concluded by stating that Claimant returning to work in the coal mines would threaten his already poor health and jeopardize the well-being of co-workers. (DX 61).

(2) Emory Robinette, M.D. (a B-Reader whose curriculum vitae is not of record) prepared a report dated June 28, 2000 based upon his examination of Claimant, which was requested by Claimant's counsel. The Claimant's coal mine employment, medical and family history, and present physical condition was summarized in the report. Claimant complained of a ten year history of breathing problems, and he reported smoking 3/4 packs of cigarettes daily, having smoked on and off since age 16, for a total of fifteen to eighteen pack-years.

The physical examination revealed diminished breath sounds and poor air movement in the chest. He found a few inspiratory crackles present in both bases with some wheezing. The chest x-ray (dated 5/19/00) showed a profusion of 3/2, predominant q/q opacities. Pulmonary function studies showed the flow rates to be decreased with a normal FVC. The FEF 25-75 was reduced, and the lung volume measurements and diffusion capacity was normal with mild elevation of the patient's carboxyhemoglobin level.

Dr. Robinette's impressions were as follows:

1. Complicated CWP with evidence of progressive massive fibrosis and an abnormal right hilar mass.
2. Mild obstructive lung disease

The medical report further stated that the pulmonary function studies had confirmed evidence of airflow obstruction. He stated that obviously Claimant was totally disabled from working as an underground coal miner based on his radiographic abnormalities. In addition, he reviewed Claimant's medical records by Dr. Forehand, which revealed two negative TB tests by Dr. Forehand. Dr. Robinette concluded that Claimant was totally disabled and has complicated CWP based upon the radiographic abnormalities. (DX 94).

(3) Kirk Hippensteel, **M.D**., (B-Reader and pulmonologist) examined the Claimant on August 21, 2000 at the Employer's request. The Claimant's coal mine employment, medical and family history, and present physical condition was summarized in the report. Claimant reported breathing problems for the last nine to ten years, reported an inability to walk a flight of stairs, and reported no history of pneumonia, tuberculosis or asthma. Dr. Hippensteel recorded a smoking history of one half pack of cigarettes daily for twenty years (i.e., ten pack years).

The physical examination of the chest revealed minimal wheezes bilaterally with no rales. The heart rhythm was regular with no gallops or murmurs. The chest x-ray showed rounded opacities in the upper and mid lung zones with profusion of 2/2 associated with partially calcified apical infiltrates and calcification in bilateral hilar lymph nodes suggestive of old granulomatous disease with a differential including tuberculosis. He reported that the CT scan showed partially calcified infiltrates in both apices with a background pattern of smaller nodules which could be simple coal workers' pneumoconiosis.

The pulmonary function test showed mild airway obstruction with a minimal degree of improvement after bronchodilator. His lungs volumes and diffusion capacity were normal. The arterial blood gas study showed minimal hypoxemia, and the carboxyhemoglobin level was elevated to 3.8% consistent with less than a pack per day smoking habit. Claimant did not undergo an exercise test.

Dr. Hippensteel concluded that he could not exclude simple coal workers' pneumoconiosis but did not find complicated CWP. Based upon the calcifications, he found that they were consistent with old granulomatous disease rather than CWP. He noted that his finding of no complicated CWP was corroborated by the non-qualifying pulmonary function data, which shows no permanent ventilatory impairment from any cause. He further stated that is also evidence that Claimant's continued smoking affects his gas exchange with an elevated carboxyhemoglobin level associated with ventilation perfusion mismatch.

In addition, Dr. Hippensteel reviewed the Claimant's medical records and critiqued the findings by other physicians. After reviewing the additional records, he concluded that Claimant could have simple CWP and the granulomatous inflammation was caused by factors other than coal dust exposure. He further stated that Claimant did not have a permanent ventilatory impairment, which supports a finding of no complicated pneumoconiosis. (DX 88).

(4) **D. L. Rasmussen, M.D.** (a B-Reader[17] whose curriculum vitae is not of record), submitted a report dated December 19, 2000. The Claimant's coal mine employment, medical and family history, and present physical condition were summarized in the report. The report stated that Claimant smoked one pack of cigarettes a day since 1967.

The physical examination showed no chest or heart sounds. The chest x-ray (interpreted by Dr. Patel) indicated pneumoconiosis with a profusion of 3/2 and q/q opacities. Ventilatory function studies revealed minimal, partially reversible obstructive insufficiency. The maximum breathing capacity was minimally reduced, and the single breath carbon monoxide diffusing capacity was minimally reduced.

The resting blood gases were normal. The Claimant underwent an exercise study for ten minutes, and the ventilation was markedly increased and oxygen transfer was normal. Overall, the studies indicated minimal loss of lung function as reflected by the ventilatory impairment. He stated that this degree of impairment would not prevent Claimant from returning to his coal mine employment.

He concluded that Claimant has x-ray changes consistent with complicated pneumoconiosis Category B which arose from coal mine employment. (DX 94).

(5) James R. Castle, M.D., (B-Reader and pulmonologist) performed a pulmonary evaluation on Claimant on May 23, 2001 at Employer's request. The Claimant's coal mine employment, medical and family history, and present physical condition were summarized in the report. Claimant was reported as having complained of shortness of breath for at least ten years or longer. Claimant reported smoking since the age of 16 and smokes less than a pack a year.

The physical examination revealed normal breath sounds with a few late expiratory wheezes over the lower lobes. There were no rales, crackles, or crepitations. The chest x-ray dated March 19, 2001 was read as showing q/r type opacities in all lung zones with a profusion of 2/2.

The spirometry showed mild airway obstruction with a minimal degree of improvement after bronchodilator. There was mild trapping and the diffusing capacity was normal. The study showed evidence of very mild airway obstruction with a minimal degree of reversibility.

Based upon the data from the evaluation, Dr. Castle made the following assessments:

1. Radiographic evidence of simple coal workers' pneumoconiosis
2. No evidence of complicated pneumoconiosis
3. Mild airway obstruction with minimal reversibility without restriction or diffusion abnormality
4. Asthmatic bronchitis, tobacco smoke induced
5. Elevated carboxyhemoglobin level of current smoker
6. Coronary artery disease, by history
7. Angina pectoris

[17] Dr. Rasmussen is listed as a certified B-Reader on the NIOSH Certified B-Readers List, which can be found at www.oalj.dol.gov.

In addition, Dr. Castle reviewed additional medical records from Claimant's records and offered an opinion on such records. Although he stated that Claimant's 25 years of coal mining work was sufficient to cause CWP, other risk factors such as tobacco use and coronary artery disease were present to cause the development of shortness of breath. He concluded that Claimant does have radiographic evidence of simple CWP but does not have complicated CWP. In assessing the x-ray evidence, he listed a number of conflicting findings, noting that he while he did not find evidence of large opacities, he did find evidence of axillary coalescence, as well as partially calcified apical lesions consistent with granulomatous disease. He also stated that the physiologic studies showed a very mild, significantly reversible degree of airway obstruction without restriction or significant diffusion abnormality. He stated that the abnormality is non-disabling and related to his smoking habit. He concluded that Claimant was not permanently and totally disabled as a result of the pulmonary process and retained the respiratory capacity to perform his usual coal mine employment. (DX 129).

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks***,** 138 F.3d 524, 536 (4th Cir.1998). A doctor's opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.,* 10 BLR 1-19, 1-22 (BRB 1987) (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). In addition, the new regulation appearing at §718.104(d) allows additional weight to be given to the opinion of a treating physician but requires certain factors, including the nature and duration of the relationship, the frequency of treatment, and the extent of treatment, to be considered.

First, I will consider the credentials of the physicians. Dr. Castle is a board certified pulmonologist with both academic appointments and publications in the area of pulmonary medicine. (DX 129). Similarly, Dr. Hippensteel is also board certified in pulmonary disease and has teaching experience along with publications in the field. (DX 34). Dr. Forehand also has academic appointments and various publications in the field. (DX 31). Drs. Rasmussen and Robinette's Curriculum Vitae are not in the record; however, their medical reports list them both as pulmonary disease physicians. While Dr. Forehand is not board certified in pulmonary medicine, he holds comparable academic appointments and publications in the field to Drs. Castle and Hippensteel. Therefore, I find that Drs. Forehand, Castle and Hippensteel are equally qualified to render medical opinions on the issue of complicated pneumoconiosis and their opinions are entitled to significant weight. Although the credentials of Drs. Robinette and Rasmussen are not of record, I do not find that to be a basis for discrediting their opinions.

Turning to the reports themselves, I find the report of Dr. Forehand to be better reasoned and documented that those of Drs. Hippensteel, Castle, Robinette, and Rasmussen. Dr. Rasmussen's report is essentially conclusory on the issue of complicated coal workers' pneumoconiosis in that he has relied solely on the X-ray findings. The reports of Drs. Hippensteel and Castle contained some analysis; however, the alternative diagnoses stated in the

reports were speculative in nature and were not supported by medical testing. Despite negative TB and histoplasmosis tests, Dr. Castle stated that there could be other granulomatous diseases, such as sarcoidosis, but this suggestion does not amount to a diagnosis. Further, he also found that Claimant's respiratory impairment was due to coronary artery disease but did not reference any objective medical data to support his findings. His discussion of the x-ray findings is confusing at best and, as noted above, I have found the x-ray evidence to weigh in favor of a finding of complicated pneumoconiosis. Similarly, Dr. Hippensteel stated that the calcifications were consistent with old granulomatous disease rather than CWP, and, while he points to other factors that led him to discount complicated CWP, his suggestion of other possible forms of granulomatous disease is speculative in nature. In contrast, the report by Dr. Forehand sufficiently considered and ruled out alternative diseases before reaching the conclusion that Claimant had complicated pneumoconiosis. The report of Dr. Robinette is corroborative of Dr. Forehand's, and they both point to some of the same factors (the presence of large opacities on x-rays, CT scan findings, the two negative TB tests, airflow obstruction on pulmonary function testing, and symptomatology) in reaching their diagnoses of complicated pneumoconiosis. However, Dr. Robinette was not as confident as Dr. Forehand in ruling out malignancy and he has not addressed the possibility of other granulomatous disease.

I find that Dr. Forehand's opinion is entitled to the most weight based upon the thorough analysis and reasoning employed in the report. Dr. Forehand based his findings on the CT scan and explained how the bilateral, non-cavitating masses were inconsistent with a finding of tuberculosis, because tuberculosis would be cavitary at that stage. Further, he also stated that tuberculosis was ruled out based upon two negative test results. Overall, his report contains the clearest explanation of the Claimant's condition and is most persuasive. Further, Dr. Forehand's report was adequately supported by documentation through the CT Chest Scan taken by Dr. Darlak, which is attached to the medical report.

Moreover, I find that Dr. Forehand's status as treating physician also entitles his findings to greater weight. Under 20 C.F.R. §718.104 (which is of questionable applicability to the instant case), consideration should be given to the relationship between the miner and any treating physician.[18] The factors in weighing the opinion of the miner's treating physician are: the nature of the relationship, duration of relationship, frequency of treatment, and extent of treatment. §718.104(d)(1)-(4). As stated in the prior decision, Dr. Forehand has been Claimant's treating physician since 1997 with two visits annually, and he also conducted the 1991 and 1997 DOL examinations. In addition, he treated the Claimant for his pulmonary condition, which is the core issue in this case. I find the fact that Dr. Forehand has treated the Claimant twice a year for the last six years[19] for his pulmonary condition provides him with a basis for rendering a more comprehensive opinion regarding the Claimant's pulmonary condition. This factor is of especial significance where, as here, speculative alternative diagnoses have been suggested. Furthermore, as stated above, Dr. Forehand also has impressive credentials, such as teaching

[18] I indicated in my previous decision (at footnote 18): "Although the standards for the administration of clinical tests and examinations only apply to clinical evidence developed after January 19, 2001, 20 C.F.R. §718.101(b), it is unclear whether the provisions of section 718.104(d), which relate to an adjudicator's weighing of the evidence, are applicable to reports generated before January 19, 2001." The Board did not address that issue in its remand decision, although it referenced case law predating the regulation. In any event, regardless of the applicability of the regulation to the instant case, it sets forth sound factors for consideration.

[19] The six-year calculation is from 1997 to 2003, the date of my initial decision.

experience and pulmonary-related publications, to support his credibility in rendering his medical opinion. For such reasons, I find that Dr. Forehand's opinion is entitled to greater weight.

The Board stated that the undersigned should assess the probative value of Dr. Forehand's opinion in light of case law concerning the treatment of treating physician's opinion. *Looney*, BRB No. 04-0119 BLA at 7. The Board stated that the Fourth Circuit has "clearly stated that neither this circuit nor the Benefits Review Board has ever fashioned a requirement or a presumption that treating physicians be given greater weight than opinions of other expert physicians." *Looney, supra, citing Consolidation Coal Co. v. Held,* 314 F.3d 184, 187, 22 B.L.R. 2-564, 2-571 (4th Cir. 2002). I must note that the determination to credit Dr. Forehand as the treating physician did not rest upon his status alone, but rather upon the unique circumstances of this case, where a number of speculative possibilities have been suggested to explain the Claimant's x-ray and CT scan abnormalities. If indeed the Claimant suffered from a malignancy, tuberculosis, sarcoidosis, or some other form of granulomatous disease, as the Employer's experts have suggested, it is reasonable to conclude that he would have been treated for such condition by a competent treating physician. It has not been suggested that Dr. Forehand is either incompetent or dishonest. Thus, in crediting Dr. Forehand as treating physician, I have not presumptively credited his opinion but have, rather, credited it based upon its own merits.

The Board further instructed that the weighing of the evidence on remand to comport with "the Fourth Circuit's mandate in *Blankenship,* which requires the administrative law judge to perform equivalency determinations to make certain, that regardless of which diagnostic technique used, the same underlying condition triggers the irrebuttable presumption." *Looney, supra* at 7, *citing Braenovich v. Cannelton Industries, Inc./Cypress Amax,* 22 B.L.R. 1-236, 1-245 (2003) and *Double B Mining, Inc. v. Blankenship,* 177 F.3d 240, 243, 22 BLR 2-561 (4th Cir. 1999). In *Blankenship*, the court stated that §921(c)(3) of the Black Lung Benefits Act states that complicated pneumoconiosis can be established if: (A) an x-ray of the miner's lungs shows at least one opacity greater than one centimeter in diameter; (B) a biopsy reveals "massive lesions" in the lungs; or (C) a diagnosis by other means reveals a result equivalent to (A) or (B). *Blankenship*, 177 F.3d at 243, *citing* 30 U.S.C. §921(c).[20] The court stated that by explicitly referencing prongs (A) and (B) as guides, prong (C) of the statute requires "plainly that equivalency determinations shall be made." *Id.* at 243, *citing Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14, 16 (3rd Cir. 1981). The Fourth Circuit holding requires that if a fact finder finds complicated pneumoconiosis under subsection (C), which allows diagnosis by other acceptable medical procedures, then such results should also be present under paragraph (a) or (b).

After reconsidering the evidence, I found that the x-ray evidence supports a finding of complicated pneumoconiosis under subsection (a). Thus, the determination that complicated pneumoconiosis is proven through medical opinion evidence under subsection (c) is also supported by my prior determination that x-ray evidence proves complicated pneumoconiosis under subsection (a), and the medical opinions under subsection (c) provide a result consistent with subsection (a). It is equally clear that Dr. Forehand has described the same underlying

[20] The regulations implementing the statute employ virtually the same language. *See* 20 C.F.R. §718.304.

condition as that causing the large opacities on x-rays. Thus, the findings are in compliance with the standard in *Blankenship.*

However, I must address the Board's concern that my previous finding that Dr. Forehand's opinion, which relied on x-ray and CT scan evidence, conflicts with the finding that the x-ray and CT scan evidence was inconclusive under Section 718.304(a) and (c), respectively. *Looney supra* at 6. As stated above, the issue is moot regarding the x-ray evidence based upon my changed findings. However, my current CT scan findings are consistent with my prior decision, thus requiring that I address the issue. Under §718.304(c), complicated pneumoconiosis can be diagnosed by other means, such as medical reports and CT scan evidence, and this section does not require that the alternative means each establish complicated pneumoconiosis so long as one medically accepted means establishes the disease. *See* §718.304(c). The requirement, as stated above in the *Blankenship,* is, rather, that the determination under subsection (c) also be supported under subsection (a) through an equivalency determination. Here, while the CT scan findings are inconclusive, they do not weigh against a finding of complicated pneumoconiosis and they are not inconsistent with crediting Dr. Forehand's report or the x-ray evidence. Moreover, as stated in my prior decision, the finding that Dr. Forehand's report supports complicated pneumoconiosis is based on additional factors, such as work history, smoking history, TB test results, and his status as treating physician, in addition to the CT scan.

After evaluating all of the newly submitted evidence under subsection (c), I find that Claimant has satisfied the preponderance of the evidence standard through medical opinion evidence. Although the CT scan evidence was equally divided on the issue among equally qualified physicians, the medical opinion evidence sufficiently supports a finding of complicated pneumoconiosis measured against the objective standards set forth in subsection (a). Therefore, complicated pneumoconiosis has been established under §718.304(c).

Section 718.304 as a whole. Looking at all the newly submitted evidence under section 718.304, I find that the preponderance of the evidence supports a finding of complicated pneumoconiosis. The x-ray evidence and medical opinion evidence supports a finding of complicated pneumoconiosis, while the CT scan evidence is in equipoise. Upon considering the x-ray evidence in conjunction with the medical opinion evidence, I find that Claimant has proven the existence of complicated pneumoconiosis.

In view of my finding on complicated pneumoconiosis, Claimant has established at least one condition of entitlement, the element of total disability, so as to establish a basis for modification,[21] as well as a material change in conditions. Therefore, I find that Claimant has meet the burden of proof required under §725.309(d), and this claim may be considered on the merits.

[21] In view of my finding of a change in conditions, it is unnecessary to determine whether modification is established based upon a mistake in determination of fact.

Merits of the Claim

Upon establishing complicated pneumoconiosis, Claimant is entitled to the irrebuttable presumption of total disability due to pneumoconiosis. Taking into consideration the evidence that was previously of record, considered along with the newly submitted evidence, I find that the Claimant suffers from complicated pneumoconiosis under section 718.304. Based upon the irrebuttable presumption in section 718.304, he has presumptively established that he is totally disabled due to pneumoconiosis Thus, he is entitled to benefits under the Black Lung Benefits Act.

Conclusion

Inasmuch as Claimant has established complicated pneumoconiosis, he has established a basis for modification based upon a change in conditions as well as a material change in conditions warranting that this subsequent claim be considered on the merits. Moreover, he has satisfied all the elements for entitlement; hence, the claim for benefits is granted.

Onset Date

The regulation set forth in §725.503 state that if a claim is awarded pursuant to a request for modification under §725.310, the date from which benefits are payable shall be determined in accordance with §725.503(d)(1) (mistake in a determination of fact) or Section 725.503(d)(2) (change in conditions). Inasmuch as Claimant's request for modification was granted based upon a change in condition, section 725.503 applies and states in relevant part:

> Benefits are payable to a miner beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mining employment, provided that no benefits shall be payable for any month prior to the effective date of the most recent denial of the claim by a district director or administrative law judge. Where the evidence does not establish the month of onset, benefits shall be payable to such miner from the month on which the claimant requested modification.

This amended regulation is applicable to claims pending on January 19, 2001. 20 C.F.R. §725.2. Because there is conflicting evidence in the record concerning the actual date the Claimant became totally disabled, I find that benefits will begin based on the date Claimant requested modification, which is January 17, 2001.

ORDER

IT IS HEREBY ORDERED that the modification claim of John P. Looney for black lung benefits be, and hereby is, **GRANTED** and Shady Lane Coal Corporation shall commence payment of benefits with an effective date of January 1, 2001.

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PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.